



## Complete Summary

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### GUIDELINE TITLE

Assessment of risk factors for preterm birth.

### BIBLIOGRAPHIC SOURCE(S)

American College of Obstetricians and Gynecologists (ACOG). Assessment of risk factors for preterm birth. Washington (DC): American College of Obstetricians and Gynecologists (ACOG); 2001 Oct. 8 p. (ACOG practice bulletin; no. 31). [80 references]

### GUIDELINE STATUS

This is the current release of the guideline.

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## SCOPE

### DISEASE/CONDITION(S)

Preterm birth

### GUIDELINE CATEGORY

Prevention

Risk Assessment

Screening

### CLINICAL SPECIALTY

Obstetrics and Gynecology

### INTENDED USERS

Physicians

#### GUIDELINE OBJECTIVE(S)

- To aid practitioners in making decisions about appropriate obstetric and gynecologic care
- To describe the various methods proposed for predicting preterm birth and the evidence for their roles in clinical practice

#### TARGET POPULATION

Pregnant women at risk of preterm birth

#### INTERVENTIONS AND PRACTICES CONSIDERED

Assessment of Risk:

1. Case history including demographic characteristics, behavioral factors, and obstetric history
2. Ultrasonography to determine cervical length, fetal fibronectin testing, or a combination of both to determine women at high risk of preterm birth
3. Note: Salivary estriol, home uterine activity monitoring, and bacterial vaginosis screening were considered but not recommended.

#### MAJOR OUTCOMES CONSIDERED

- Risk factors for preterm birth
- Predictive value of home uterine activity monitoring (HUAM), salivary estriol, screening for bacterial vaginosis, fetal fibronectin (fFN) screening, and cervical ultrasonography
- Sensitivity and specificity of salivary estriol measurement, fFN screening, and cervical ultrasonography

### METHODOLOGY

#### METHODS USED TO COLLECT/SELECT EVIDENCE

Hand-searches of Published Literature (Primary Sources)  
Hand-searches of Published Literature (Secondary Sources)  
Searches of Electronic Databases

#### DESCRIPTION OF METHODS USED TO COLLECT/SELECT THE EVIDENCE

The MEDLINE database, the Cochrane Library, and American College of Obstetricians and Gynecologists' (ACOG's) own internal resources and documents were used to conduct a literature search to locate relevant articles published between January 1985 and May 2000. The search was restricted to articles published in the English language. Priority was given to articles reporting results of original research, although review articles and commentaries also were

consulted. Abstracts of research presented at symposia and scientific conferences were not considered adequate for inclusion in this document.

Guidelines published by organizations or institutions such as the National Institutes of Health and the American College of Obstetricians and Gynecologists were reviewed, and additional studies were located by reviewing bibliographies of identified articles.

#### NUMBER OF SOURCE DOCUMENTS

Not stated

#### METHODS USED TO ASSESS THE QUALITY AND STRENGTH OF THE EVIDENCE

Weighting According to a Rating Scheme (Scheme Given)

#### RATING SCHEME FOR THE STRENGTH OF THE EVIDENCE

Studies were reviewed and evaluated for quality according to the method outlined by the U.S. Preventive Services Task Force:

I Evidence obtained from at least one properly designed randomized controlled trial

II-1 Evidence obtained from well-designed controlled trials without randomization

II-2 Evidence obtained from well-designed cohort or case-control analytic studies, preferably from more than one center or research group

II-3 Evidence obtained from multiple time series with or without the intervention. Dramatic results in uncontrolled experiments also could be regarded as this type of evidence.

III Opinions of respected authorities, based on clinical experience, descriptive studies, or reports of expert committees

#### METHODS USED TO ANALYZE THE EVIDENCE

Review of Published Meta-Analyses  
Systematic Review

#### DESCRIPTION OF THE METHODS USED TO ANALYZE THE EVIDENCE

Not stated

#### METHODS USED TO FORMULATE THE RECOMMENDATIONS

Expert Consensus

## DESCRIPTION OF METHODS USED TO FORMULATE THE RECOMMENDATIONS

Analysis of available evidence was given priority in formulating recommendations. When reliable research was not available, expert opinions from obstetrician-gynecologists were used. See also the "Rating Scheme for the Strength of Recommendations" field regarding Grade C recommendations.

## RATING SCHEME FOR THE STRENGTH OF THE RECOMMENDATIONS

Based on the highest level of evidence found in the data, recommendations are provided and graded according to the following categories:

Level A — Recommendations are based on good and consistent scientific evidence.

Level B — Recommendations are based on limited or inconsistent scientific evidence.

Level C — Recommendations are based primarily on consensus and expert opinion.

## COST ANALYSIS

A formal cost analysis was not performed and published cost analyses were not reviewed.

## METHOD OF GUIDELINE VALIDATION

Internal Peer Review

## DESCRIPTION OF METHOD OF GUIDELINE VALIDATION

Practice Bulletins are validated by two internal clinical review panels composed of practicing obstetrician-gynecologists generalists and subspecialists. The final guidelines are also reviewed and approved by the American College of Obstetricians and Gynecologists (ACOG) Executive Board.

# RECOMMENDATIONS

## MAJOR RECOMMENDATIONS

The grades of evidence (I-III) and levels of recommendations (A-C) are defined at the end of "Major Recommendations" field.

The following recommendation is based on good and consistent scientific evidence (Level A):

- There are no current data to support the use of salivary estriol, home uterine activity monitoring (HUAM), or bacterial vaginosis (BV) screening as strategies to identify or prevent preterm birth.

The following recommendations are based on limited or inconsistent scientific evidence (Level B):

- Screening for risk of preterm labor by means other than historic risk factors is not beneficial in the general obstetric population.
- Ultrasonography to determine cervical length, fetal fibronectin (fFN) testing, or a combination of both may be useful in determining women at high risk for preterm labor. However, their clinical usefulness may rest primarily with their negative predictive value given the lack of proven treatment options to prevent preterm birth.
- Fetal fibronectin testing may be useful in women with symptoms of preterm labor to identify those with negative values and a reduced risk of preterm birth, thereby avoiding unnecessary intervention.

#### Definitions:

##### Grades of Evidence

I Evidence obtained from at least one properly designed randomized controlled trial

II-1 Evidence obtained from well-designed controlled trials without randomization

II-2 Evidence obtained from well-designed cohort or case-control analytic studies, preferably from more than one center or research group

II-3 Evidence obtained from multiple time series with or without the intervention. Dramatic results in uncontrolled experiments also could be regarded as this type of evidence.

III Opinions of respected authorities, based on clinical experience, descriptive studies, or reports of expert committees

##### Levels of Recommendation

Level A — Recommendations are based on good and consistent scientific evidence.

Level B — Recommendations are based on limited or inconsistent scientific evidence.

Level C — Recommendations are based primarily on consensus and expert opinion.

#### CLINICAL ALGORITHM(S)

None provided

## EVIDENCE SUPPORTING THE RECOMMENDATIONS

### TYPE OF EVIDENCE SUPPORTING THE RECOMMENDATIONS

The type of supporting evidence is identified and graded for each recommendation (see "Major Recommendations").

## BENEFITS/HARMS OF IMPLEMENTING THE GUIDELINE RECOMMENDATIONS

### POTENTIAL BENEFITS

Improved understanding of the various methods proposed for predicting preterm birth

### POTENTIAL HARMS

Not stated

## QUALIFYING STATEMENTS

### QUALIFYING STATEMENTS

These guidelines should not be construed as dictating an exclusive course of treatment or procedure. Variations in practice may be warranted based on the needs of the individual patient, resources, and limitations unique to the institution or type of practice.

## IMPLEMENTATION OF THE GUIDELINE

### DESCRIPTION OF IMPLEMENTATION STRATEGY

An implementation strategy was not provided.

## INSTITUTE OF MEDICINE (IOM) NATIONAL HEALTHCARE QUALITY REPORT CATEGORIES

### IOM CARE NEED

Staying Healthy

### IOM DOMAIN

Effectiveness

## IDENTIFYING INFORMATION AND AVAILABILITY

### BIBLIOGRAPHIC SOURCE(S)

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#### ADAPTATION

Not applicable: The guideline was not adapted from another source.

#### DATE RELEASED

2001 Oct

#### GUIDELINE DEVELOPER(S)

American College of Obstetricians and Gynecologists - Medical Specialty Society

#### SOURCE(S) OF FUNDING

American College of Obstetricians and Gynecologists (ACOG)

#### GUIDELINE COMMITTEE

American College of Obstetricians and Gynecologists (ACOG) Committee on Practice Bulletins-Obstetrics

#### COMPOSITION OF GROUP THAT AUTHORED THE GUIDELINE

Not stated

#### FINANCIAL DISCLOSURES/CONFLICTS OF INTEREST

Not stated

#### GUIDELINE STATUS

This is the current release of the guideline.

#### GUIDELINE AVAILABILITY

Electronic copies: None available

Print copies: Available for purchase from the American College of Obstetricians and Gynecologists (ACOG) Distribution Center, PO Box 4500, Kearneysville, WV 25430-4500; telephone, 800-762-2264, ext. 192; e-mail: [sales@acog.org](mailto:sales@acog.org). The ACOG Bookstore is available online at the [ACOG Web site](#).

#### AVAILABILITY OF COMPANION DOCUMENTS

None available

## PATIENT RESOURCES

None available

## NGC STATUS

This NGC summary was completed by ECRI on September 23, 2004. The information was verified by the guideline developer on December 9, 2004.

## COPYRIGHT STATEMENT

This NGC summary is based on the original guideline, which is subject to the guideline developer's copyright restrictions.

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